Board of Behavioral Sciences
1625 North Market Blvd., Suite S200, Sacramento, CA 95834
Telephone: (916) 574-7830 TTY: (800) 326-2297
www.bbs.ca.gov

LICENSED MARRIAGE AND FAMILY THERAPIST
IN-STATE EXPERIENCE VERIFICATION
OPTION 1 – NEW STREAMLINED METHOD

This form is to be completed by the applicant's California supervisor and submitted by the applicant with his or her *Application for Licensure and Examination*. All information on this form is subject to verification.

- Use this "Option 1" form to report hours under the NEW streamlined method
- Use separate forms for pre-degree and post-degree experience
- Use separate forms for each supervisor and each employment setting
- Ensure that the form is complete and correct prior to signing
- Provide an original signature and have the supervisor initial any changes
- Do not submit your *Weekly Summary* forms unless specifically requested by the Board

The hours on this form were earned as (mark one):
☐ Pre-Degree
☐ Post-Degree
☐ Practicum Remediation

APPLICANT NAME:

Last	First	Middle	Intern Number IMF

SUPERVISOR INFORMATION:

Supervisor's Last Name	First	Middle

Address: Number and Street			
City	State	Zip Code	Business Phone

License Type	License Number	State	Date First Licensed

- If a Physician, were you certified in Psychiatry by the American Board of Psychiatry and Neurology during the entire period of supervision? ☐ N/A ☐ Yes: Date Board Certified: _____
  ☐ No Certification #: _____

- If a LPCC, did you meet the qualifications to treat couples and families during the entire period of supervision, as specified in California law? ☐ N/A ☐ Yes: Date you met the qualifications:
  ☐ No _____

Applicant: Last	First	Middle

APPLICANT'S EMPLOYER INFORMATION:

Name of Applicant's Employer			Business Phone
Address Number and Street	City	State	Zip Code

1. Was this experience gained in a setting that lawfully and regularly provides mental health counseling or psychotherapy? ☐ Yes ☐ No
2. Was this experience gained in a private practice setting? ☐ Yes ☐ No
3. Was this experience gained in a setting that provided oversight to ensure that the applicant's work meets the experience and supervision requirements and is within the scope of practice? ☐ Yes ☐ No
4. For hours gained as an Intern ONLY: Was the applicant receiving pay? ☐ Yes ☐ No

   If YES, attach a copy of the applicant's W-2 statement for each year experience is claimed. If a W-2 has not yet been issued for this year, attach a copy of the current paystub. If applicant volunteered, submit a letter from the employer verifying volunteer status. ☐ N/A (pre-degree experience)

EXPERIENCE INFORMATION:

1. Dates of experience being claimed:	From: _____ mm/dd/yyyy	To: _____ mm/dd/yyyy
2. How many weeks of supervised experience are being claimed? _____ weeks		

3. Hours of Experience:	**Logged Hours**
a. Total Direct Counseling Experience *(Minimum 1,750 hours)*	
• Of the above hours, how many were gained diagnosing and treating Couples, Families and Children? *(Minimum 500 of the 1,750 hours)*	
b. Total Non-Clinical Experience *(Maximum 1,250 hours)*	

4. Face-to-face supervision:	**Hours Per Week**	**Logged Hours**
a. Individual		
b. Group (group contained no more than **8** persons)		

NOTE: Knowingly providing false information or omitting pertinent information may be grounds for denial of the application. The Board may take disciplinary action on a licensee who helps an applicant obtain a license by fraud, deceit or misrepresentation.

Signature of Supervisor: _____ Date: _____